EXHIBIT B

INTERNATIONAL SPECIALTY INSURANCE, INC

HELPING PROTECT WHAT YOU'VE ACHIEVED

QUESTIONS? 800-849-0474

INSTRUCTIONS: Print in black and initial all changes. Answer all questions in their entirety. Any unanswered questions will delay the processing "N/A" or "None" are unsatisfactory answers and will not be accepted.

Disability Insurance Claim Form

THANK YOU FOR NOTIFYING US OF YOUR CLAIM.

PLEASE ENSURE:

- You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim. If any question is not applicable,please state 'N/A'.
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- Your attending doctor fully completes the statement.

Policyholder/Insured:

Roc Nation Sports - Roc Nation Boxing, LLC
FIRST NAME M.I. LAST NAME

Claimant/Insured Person:

Andre | | Ward
FIRST NAME M.I. LAST NAME

Date of Birth:

2 | 23 | 84
MM DD YYYY

ACCIDENT OR SICKNESS DETAILS

A. Please give date of accident or first manifestation of illness:

October, 2016. Saw doctor on 10/19/16.

B. If an accident, where the accident occurred:

In my personal boxing gym.

C. If an accident, how the accident occurred:

Sparring - fight simulation.

D. The injuries sustained or illness which required treatment:

PLEASE PROVIDE DETAILS

Pain, Swelling unlike anything ever experienced

E. Have you ever suffered from this type of injury or illness before?

PLEASE PROVIDE DETAILS

NO

F. Have you previously claimed under this or a similar policy?

IF YES, PLEASE GIVE THE NAME, ADDRESS & POLICY NUMBER OF ANY OTHER INSURANCE THAT MAY COVER THIS INJURY.

NO

INTERNATIONAL SPECIALTY INSURANCE, INC.

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Disability Insurance Claim Form

The date you ceased working: 9 / 8th / 2017

The date you returned to work, or plan to: unable to do so.

Did you attended a hospital? ☐ YES ☒ NO

NAME OF HOSPITAL

NAME OF DOCTOR OR CONSULTANT SURGEON

Date Admitted: N/A

Date Released: N/A

Was any period spent in intensive care? ☐ YES ☒ NO

IF YES, PLEASE PROVIDE DETAILS INCLUDING DATES: N/A

Were you subsequently confined to your home on medical grounds? ☐ YES ☒ NO

IF YES, PLEASE PROVIDE DETAILS OF DATES AND TIMES THAT YOU FELT IT RELEVANT: N/A

Is there any additional information that you feel is relevant? ☐ YES ☒ NO

IF YES, PLEASE PROVIDE DETAILS

DECLARATION

I declare that all the information given is to the best of my knowledge and belief, full, true and correct. If any information supplied on this form is untrue I accept that my claim may be withdrawn and that no payment will be made to me.

Signed by the claimant: [signature] Date (MONTH/DAY/YEAR): 10/12/17

x Signed by Policy Owner x 10/13/17 Date

INTERNATIONAL

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INSTRUCTIONS Print in black and initial a changes Answer all questions in their entirety Any unanswered questions will delay the processing "N/A" or "none" are unsatisfactory answers and will not be accepted

This section must be fully completed by attending doctor. Any fee for completion of this section is the responsibility of the insured person.

DOCTORS STATEMENT

Patient's information:
Andre | M | Ward

Date of Birth.
2 | 23 | 84 X [redacted] 185 6'1"

Final diagnosis .

REDACTED

When did the patient first receive medical attention for this condition?
Oct 19 2016 . Had MRI

Has the patient ever suffered with this or any similar condition before the present episode?
No

Are you the patient's usual doctor?
Yes

On what date did incapacity commence?
Oct | 2016

Is patient still incapacitated?
Yes

Was the patient hospitalised as a result of this condition?
No

Thank you for your assistance in completing this form

Signature MDillingham MD
Date 10/3/17 MD
Qualifications

Name Michael D Illingham MD
Address 520 Arguello Suite 100 Redwood City CA 94063
Telephone No. 650 995 2825

INTERNATIONAL
SPECIALTY INSURANCE, INC

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Disability Insurance Claim Form

ACCESS TO MEDICAL REPORTS 1988

This is a summary of your principal rights under the Act, which is concerned with reports provided for employment or insurance purposes by a medical practitioner who is, or has been, responsible for your care.

Option A. You may withhold your consent for the report from a medical practitioner.

Option B. You may consent to the application but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report. It will not be sent to you automatically).

The medical practitioner will be informed that you wish to have access to the report and will allow 21 days for you to see and approve it before it is supplied to the applicant. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that your consent to its being supplied.

When you see the report, if there is anything in it which you consider incorrect or misleading, you can request (but this request must be in writing) that the medical practitioner amend the report, but he/she is not obliged to do so. If the medical practitioner refuses to amend it, you may:

i) withdraw consent for the report to be issued

ii) ask the medical practitioner to attach to the report a statement setting our your own views.

iii) agree to the report being unchanged.

NOTE: The medical practitioner is not obliged to show you any parts of the report which he/she believes might cause serious harm to your physical or mental health or that of others, or which would reveal information about a third party or the identity of a third party who has supplied the practitioner with the information about your health, unless the third party also consents. In those circumstances the medical practitioner will inform you and your access to the report will be appropriately limited.

Option C. You may consent to the application for the report, but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made, and notify the medical practitioner in writing, he/she should be allowed 21 days to elapse after such notification so that you may arrange to have access to the report (if the report has not already been supplied before you change your mind).

Option D. Whether or not you do decide to seek access to the report before it is supplied, you have the right to seek access to it from the medical practitioner at any time up to six months after it was supplied.

Please note that where a copy of the medical report is supplied to you, the practitioner may charge a reasonable fee to cover the cost of supplying it.

INTERNATIONAL SPECIALTY INSURANCE, INC.

[redacted]

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Disability Insurance Claim Form

Full Name of Claimant:
Andre | | Ward

Claimant Date of Birth: 2 | 23 | 84
MO DD YYYY

Full Name of Patient (if different from Claimant)
FIRST NAME | MI | LAST NAME

ADDRESS

CITY | STATE | ZIP CODE

SOCIAL SECURITY NO

Patient Date of Birth: 2 | 23 | 84
MO DD YYYY

GENDER ☒ MALE ☐ FEMALE WEIGHT 185 HEIGHT 6' 1"

General Practitioner:

ADDRESS

CITY | STATE | ZIP CODE

Specialist:
Michael Dillingham MD.
ADDRESS 500 Arguello St. #100
CITY Redwood City, CA 94063

I hereby consent to a medical report or my records being supplied in confidence to the Insurers Medical Adviser by the above named doctor(s) or their nominated deputy. I understand that it may be necessary for the Insurers or their representatives to discuss some of these matters in the strictest confidence with their personnel in order to assess the claim being made under the relevant Policy/Policies.

I understand my rights under the Access to Medical Reports Act 1988 and have read the summary of my principal rights under this Act (please see overleaf)

Delete where inapplicable

I DO NOT wish to have access to the medical report or notes before they are supplied.

I DO wish to have access to the medical report or notes before they are supplied and understand that I have 21 days in which to make the necessary arrangements with my medical practitioner, who is entitled to charge a fee for this service.

I agree to be seen and examined by the Insurers' Medical Adviser. I also understand that any information or opinions drawn from this examination of me may also be divulged to the Insurers (or agreed third parties) and also understand that this may be used in making underwriting and claims decisions. A copy of this consent shall be valid as the original

Signature of Proposed Insured — Date (MM/DD/YYYY) 10/12/17

Signature of Policyholder — Date 10/13/17

INTERNATIONAL SPECIALTY INSURANCE INC

[redacted]

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HIPAA Compliant Authorization for Release of Health Related Information

Name of Proposed Insured: Andre I Ward

Date of Birth: 2 / 23 / 84

I authorize any health plan, physician, health care professional, Hospital, Clinic, Laboratory, pharmacy or pharmacy benefit manager, or other medical or medically related facility, insurance or reinsurance company, the Medical Information Bureau or any other organization, institution or person that has any records or knowledge of me or my health, to give to International Specialty Insurance, any such information, to the extent permitted by law.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or team trainer to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that International Specialty Insurance may: 1) work with underwriters to have the exclusions (if any) removed from my insurance policy; 2) conduct other legally permissible activities that relate to any coverage I have or have applied for with International Specialty Insurance.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is valid as the original. I understand I have the right to revoke this authorization in writing, at any time, by providing written notification to International Specialty Insurance at 110 Oakwood Drive, Suite 420, WinstonSalem, NC 27103. I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me.

I understand that any information that is disclosed is in pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by International Specialty Insurance except as authorized by me or as required by law. I understand that International Specialty Insurance may not be able to process my application if I refuse to sign this Authorization. I further understand that if coverage has been issued, International Specialty Insurance may not be able to assist in removing medical exclusions placed on my insurance policy by underwriters or make any benefit payments. I understand that I or any authorized representative may receive a copy of this Authorization upon request.

Signature of Proposed Insured/Patient or Date Personal Representative

Date (MONTH/DAY/YEAR): 10/12/17

Signature of Witness

Date (MONTH/DAY/YEAR)